Medicaid Reform in Virginia: Eligibility and Benefits Under PPACA

Presentation to the

Health Reform Initiative Advisory Committee
Medicaid Reform Task Force

Department of Medical Assistance Services

November 9, 2010

Presentation Outline

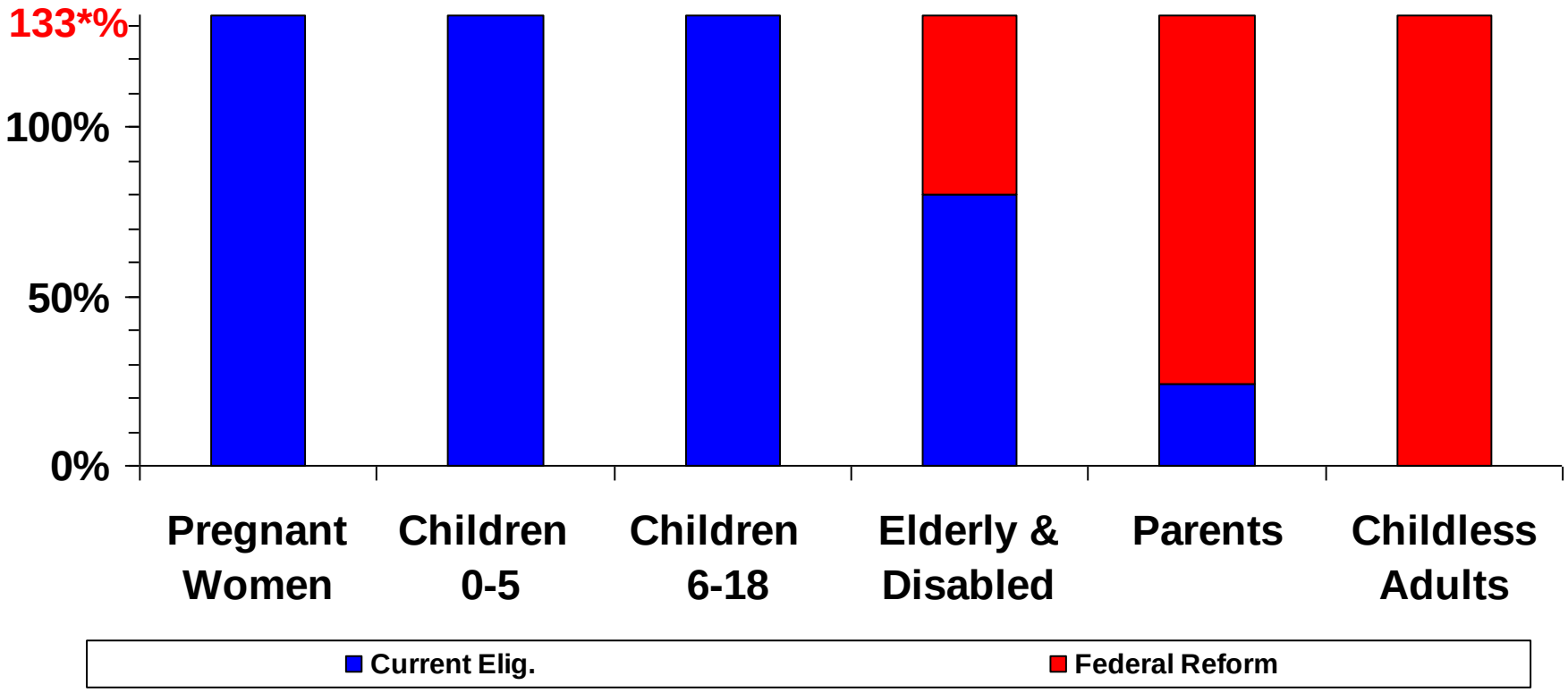
- ***Background on PPACA Eligibility Expansion***
- **The Citizen-Centric Eligibility Portal**
- **Medicaid Benefit Design Options under PPACA**

Major Medicaid/CHIP Provisions of Federal Health Reform

- **Effective January 1, 2014: Expansion of Medicaid Coverage of Adults to 133% of the Federal Poverty Level (FPL), plus a 5% income disregard (also modifies income calculation generally)**
  - **Expands coverage for groups currently under Medicaid**
    1. **Low Income Families with Children (LIFC): Parents and other caretaker adults are currently covered up to 24% FPL (on average)**
    2. **Non-Dual Disabled Adults (without need for long-term care): This coverage group is currently limited to 80% FPL**
  - **Includes new coverage groups under Medicaid**
    1. **Childless adults: currently not covered unless they meet some other coverage group (aged, blind, disabled, for example)**
    2. **Former foster care "children" up to age 26 (regardless of income)**

Major Medicaid/CHIP Provisions of Federal Health Reform

(continued)



*Does not include 5% income disregard

Major Medicaid/CHIP Provisions of Federal Health Reform

(continued)

- All New Coverage (new groups or coverage of existing groups above current levels) is funded with enhanced federal match:

Year	Match by CY (January to December)		Match by SFY (July to June)	
	Federal	State	Federal	State
2014	100%	0%	100%	0%
2015	100%	0%	100%	0%
2016	100%	0%	100%	0%
2017	95%	5%	97.5%	2.5%
2018	94%	6%	94.5%	5.5%
2019	93%	7%	93.5%	6.5%
2020	90%	10%	91.5%	8.5%
2021-beyond	90%	10%	90%	10%

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

IMPORTANT NOTE:

The following represents an estimate of the fiscal impact of federal health reform related to major provisions affecting Medicaid and CHIP (FAMIS) only. Federal health reform has multiple aspects affecting the Commonwealth, including additional provisions with an impact on Medicaid and/or CHIP which are not included herein.

The Department of Medical Assistance Services is continually revising these estimates based on emerging information and guidance from CMS and other entities. This estimate represents the agency's current understanding of the provisions discussed herein and should be considered as preliminary and subject to change as our understanding of health reform evolves

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

(continued)

- **Estimated Increase in Monthly Enrollment:**
  - **Between 270,000 – 425,000 new enrollees (average monthly recipients)**
    - **Includes approximately 50,000 estimated children currently eligible but un-enrolled entering the program due to the coverage mandate**
      - **These costs would be reimbursed at the normal federal match (this is not "new" coverage)**
- **This provision is estimated to cost between $2.1 – $2.8 billion (using the enrollment estimates above as the lower and upper bounds) in State funding through 2022 (includes 1.5% add-on for administrative costs)**

NOTE: 2021 is the first full SFY where the FMAP settles to 90% (for newly eligibles)– 2022 completes that biennium

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

(continued)

SFY	Federal Match Rate*	GF (STATE) Expansion Cost (lower bound)**	NGF (FEDERAL) Expansion Cost (lower bound)**	GF (STATE) Expansion Cost (upper bound)**	NGF (FEDERAL) Expansion Cost (upper bound)**
2014	100.00%	$54,197,792	$918,393,808	$56,814,807	$1,464,138,285
2015	100.00%	$113,548,404	$1,928,893,955	$119,044,135	$3,074,957,358
2016	100.00%	$118,958,865	$2,025,605,613	$124,729,382	$3,228,972,186
2017	97.50%	$172,678,469	$2,079,114,233	$210,609,017	$3,310,777,629
2018	94.50%	$241,574,093	$2,122,808,244	$321,559,267	$3,375,896,711
2019	93.50%	$274,075,336	$2,208,526,118	$372,115,103	$3,510,213,674
2020	91.50%	$331,490,309	$2,275,241,217	$463,948,267	$3,612,496,949
2021	90.00%	$382,306,899	$2,354,761,204	$544,631,764	$3,735,635,713
2022	90.00%	$400,613,802	$2,473,307,706	$571,054,909	$3,923,225,941
TOTAL		**$2,089,443,970**	**$18,386,652,097**	**$2,784,506,651**	**$29,236,314,446**

*Represents a blended match rate based on SFY, not calendar year

**This table presents expansion costs only, potential Medcaid savings under reform are not included in this table

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

(continued)

- **In addition to the Expansion costs, there are also provisions currently estimated to produce a net savings to the Commonwealth**

Provision	STATE Savings Estimate (2010-2022)
CHIP Match Rate Increase	$56,770,696
Pharmacy Rebate Changes	$428,698,482
DSH Reductions	$140,391,085
TOTAL Estimated Potential Savings	$625,860,262

*This table only includes estimated savings associated with these three major items - there are likely additional savings items attributable to Medicaid reform within the federal legislation that are not yet included in this analysis. Furthermore, this table does not address potential savings achieved through health reform outside of the Medicaid program."

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

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Estimate Component	Lower Bound Enrollment Increase	Upper Bound Enrollment Increase
Assumed Enrollment Increase	271,047	425,930
Expansion Cost	$2,089,443,970	$2,784,506,651
Reform Savings	$625,860,262	$625,860,262
Net Estimated STATE Cost of Reform (SFYs 2010-2022)	$1,463,583,708	$2,158,646,389

Note: these costs do not include potential costs associated with reversing eligibility changes prohibited by health reform as contained in the 2010 Appropriations Act

Implementation Challenges for Virginia Medicaid

- **Reform of the Eligibility Determination Process and Case Maintenance**
  - **Coordination/Interaction with Health Exchange(s) and other entities**
  - **Improvement/creation of automated electronic eligibility determination and tracking systems and connectivity with existing systems**
  - **Increased volume of applications and maintenance of caseload**
  - **Potential for multiple eligibility rules due to differing federal match rates**
- **Definition of the benefit package for the expansion population**
  - **"Benchmark" packages not fully defined**
  - **Considerations regarding coverage of non-traditional (Medicaid exclusive) healthcare services (certain mental health services, for example)**

Implementation Challenges for Virginia Medicaid

(continued)

- **Access to care for current and new enrollees**
  - **Provider capacity concerns in light of additional coverage (both commercial and Medicaid)**
    - **Results in upward pressure on Medicaid payment rates**
    - **Potential reform of administrative processes in Medicaid**
- **Sustainability of funding for the Medicaid program in Virginia**

OPPORTUNITIES

- **Ability to provide healthcare coverage to populations currently unable to afford coverage with significantly increased federal funding**
- **Provides significant momentum to examine and implement needed reforms of both Medicaid and the healthcare system generally**

Presentation Outline

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Benchmark Benefits

- **States are required to provide benchmark or "benchmark equivalent" benefit packages to most individuals in the Medicaid expansion population**
  - **The goal of benchmark packages is to allow states greater flexibility to provide alternative benefit packages to individuals outside the core Medicaid populations**
  - **States were first allowed to cover children in the CHIP program through benchmark packages. Subsequently, the Deficit Reduction Act of 2005 (DRA) allowed states to use a benchmark plan to cover selected Medicaid populations**

Benchmark Benefits

(continued)

- **Certain populations are exempted from mandatory participation in benchmark coverage, but could participate (if such plans are offered) at their option:**
  - **Pregnant women**
  - **Women in the breast / cervical cancer program**
  - **Blind or disabled individuals**
  - **Medicare-eligible individuals**
  - **Medically frail and special needs individuals**
  - **Eligible long-term care beneficiaries, institutionalized individuals, hospice patients**
  - **Certain low-income parents, foster care and adopted children, and individuals receiving only emergency services**

    [while mandatory coverage under benchmark plans for children is not prohibited, the EPSDT program essentially limits the effect of benchmark coverage for children]

Benchmark Benefits

(continued)

- **Benchmark packages are defined in federal regulations as coverage equaling one of the following:**
  - **Federal Employee Health Benefit Package**
  - **State Employee Coverage**
  - **Coverage offered through the largest commercial HMO plan in the state**
  - **Any other plan approved by the HHS Secretary**

- **"Benchmark equivalent" coverage is a plan designed by the state which includes required categories of benefits and is actuarially equivalent to one of the benchmark packages**

Benchmark Benefits

(continued)

- **Benchmark and benchmark equivalent plans must meet certain additional requirements that apply to traditional coverage under Medicaid**
  - **They must cover the following Medicaid services:**
    - **Non emergency transportation services**
    - **Family planning services**
    - **Services provided by federally qualified health centers**
  - **States providing benchmark equivalent coverage must provide coverage of mental health services and prescription drugs**
  - **Coverage provided through an MCO must meet Medicaid managed care requirements**
  - **States must secure public input prior to implementing a benchmark plan**

“Essential Health Benefits”

- **Under PPACA, benchmark benefits must include the “essential health benefits” required of the Exchange plans. Essential health benefits are those provided by a typical employer plan and include:**
  - **ambulatory and emergency services**
  - **maternity care**
  - **mental health and substance abuse services**
  - **prescription drugs**
  - **rehabilitative services**
  - **laboratory services**
  - **preventive and wellness services including chronic disease management**
  - **pediatric services including oral and vision care**

"Minimal Essential Coverage"

- **PPACA also ties benchmark coverage for the expansion population under Medicaid to the "Minimal Essential Coverage" offered through the Exchange**
  - **Minimal essential coverage corresponds to the "Bronze" level of benefits under the Exchange**
    - **The "Bronze" level represents a level of coverage at an actuarial equivalent of 60 percent of the full scope of the Essential Benefits Plan (which is based on the "typical employer plan, as determined by the Secretary"**
    - **The "Silver" level = 70 percent**
    - **The "Gold" level = 80 percent**
    - **The "Platinum" level = 90 percent**

      [the Exchange also includes a "Catastrophic" plan option]

Medicaid Cost Sharing

- **Federal Law dictates the extent to which cost sharing can be imposed on Medicaid recipients**
  - **Several groups of beneficiaries have always been exempted from cost sharing; the rest have been subject to nominal amounts**
  - **The DRA changed this somewhat, providing states additional flexibility to increase cost sharing for higher income recipients as well as authority to enforce payment of the cost sharing**
- **Cost sharing for the Medicaid expansion population follows the DRA guidelines**

Medicaid Cost Sharing

(continued)

- **The following recipients and/or services are excluded from cost sharing in Medicaid:**
  - **Services furnished to individuals under 18**
  - **Services furnished to pregnant women**
  - **Services furnished to individuals who are inpatients in a hospital, nursing facility intermediate care facility for the mentally retarded**
  - **Services furnished to individuals receiving hospice care**
  - **Women in the Medicaid breast / cervical cancer programs**
  - **Individuals receiving family planning services and emergency services**

Medicaid Cost Sharing

(continued)

- The Virginia Medicaid expansion population will largely consist parents (who are only currently covered to roughly 24% of FPL) and childless adults
- The following table outlines the cost sharing guidelines for this population:

	Less than 100% FPL	101%-133% FPL
Premiums	Not allowed	
Most Services	Nominal	Up to 10% of the cost of the service or a nominal charge
Prescription Drugs	Nominal	
Non-emergency use of the E R	Nominal	Up to twice the nominal amount
Preventive services	Nominal	Up to 10% of the cost of the service or a nominal charge
Cap on total cost sharing	5% of family income	
Service may be denied for not paying cost sharing	No	Yes

Outstanding Issues to Consider

- **The recently published Final Regulations covering benchmark benefit packages do not include changes made in PPACA**
- **The Secretary has not yet defined the scope of "essential health benefits" (the basis of the various actuarial equivalents required)**
  - **It is therefore still unclear as to the *required* scope of coverage for the Medicaid Expansion population**
  - **Regardless of the minimum coverage required, benefit design (including cost sharing) for the Medicaid expansion population will impact:**
    - **administrative requirements for Medicaid and the Exchange (eligibility tracking to determine coverage level and issues related to churn between Medicaid and the Exchange, for example); and,**
    - **cost of coverage for the Commonwealth (inclusion of non-traditional, Medicaid-only benefits, for example)**

Coordination with the Exchange

- **PPACA requires states to coordinate eligibility for Medicaid, CHIP and subsidized private coverage through the Exchange**
  - **Since a significant number of individuals may "migrate" between these programs when their income or health status changes, it will also be important to coordinate the delivery of care between these programs**
  - **There are few federal requirements in this area beyond requiring benchmark packages to include the essential health benefits required of Exchange plans**
  - **How care is coordinated between these programs is largely left to the States' discretion**

Benefit Design Implications on Cost for the Commonwealth

- **As "essential health benefits" is statutorily required to be based on typical employer coverage, it appears that certain non-traditional, Medicaid-only services may not be required under the benchmark or benchmark equivalent coverage options for the Medicaid population**
- **If not required (which will depend on guidance from the HHS Secretary), the Commonwealth may still wish to provide additional coverage in order to access federal funding for certain services**
  - **Example:**
    - **VACSB recently provided estimates (based on national projections) that approximately 34 percent of the Medicaid expansion population will have mental health and/or substance use treatment needs**
    - **Many of these individuals (currently ineligible for Medicaid) are served through non-federally matched funding**
    - **To the extent the non-traditional, Medicaid-only community mental health services are included in the expansion benefit, federal funding may offset a portion of current un-matched obligations**